



If the MRI is considered urgent, please call the Radiology RN at 865-541-8116

# MRI Physician Order

**STEP 1** COMPLETE all information and FAX to Radiology: 865-541-8287 Date: \_\_\_/\_\_\_/\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Alternate Phone: ( ) \_\_\_\_\_

Contact Name: \_\_\_\_\_ Patient's Wt. \_\_\_\_\_ Ht. \_\_\_\_\_

**CHECK EXAM ORDERED**

- Abdomen
- Brain
- C-Spine
- T-Spine
- L-Spine
- Cardiac
- Chest
- Entire Spine
- Extremity (please specify)
- MRA
- MRCP
- Pelvis

**Contrast Requested:** \_\_\_ Without  
\_\_\_ With and Without

**Reason for Exam:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\*\*Please fax current H & P if patient will require sedation or is less than 12 years old\*\*\***

Physician's Signature (REQUIRED): \_\_\_\_\_

Print Physician's Name: \_\_\_\_\_

Office Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

**STEP 2** Appointment Completed by Radiology and Faxed to Ordering Physician

(Radiology staff calls family for medical history and schedules MRI)

Appointment Date/Time: \_\_\_\_\_

**STEP 3** Ordering Physician office obtains precert # and faxes this completed form to Admitting 865-541-8289 at least 24 hours prior to the appointment. Scheduled exams will not be performed without a precert #.

Precertification #: \_\_\_\_\_

ICD.9 Code: \_\_\_\_\_ CPT CODE: \_\_\_\_\_

If you have any questions, you may speak to a Radiology RN or leave a message at 865-541-8398.